New Provider Application

Terms of Agreement

Please review all information prior to completing your application to determine if you are able to meet the terms of the providership and create a learning module consistent with the required elements outlined in the syllabus.

After completing the application, please send to the designated address indicated on the application form. This office will review your application within 30 days. If approved, you will receive a letter with a provider number assigned to you or your facility. This provider number is used when issuing certificates of completion of the training to your attendees. It designates the approval of the course by the Department of Health. The letter will also specify the target population that you have been approved to train.

Once you have been issued a provider number and your course work is developed you may begin training. The providership will be valid for a period of 6 years.

If you are not approved as a provider, you will receive a letter indicating the reasons for the determination.

Thank you for applying to teach this course work. This enables New York State's professionals to learn important and current information in infection control principles, as well as meet their professional obligations.

Should you have any question regarding this application, please call this office at (518) 486-29385 or e-mail to ICP@health.state.ny.us.

Print, Complete and Mail or Fax to:	
New York State Department of Health P.O. Box 2051 Empire State Plaza Station Albany, NY 12220-0051 (518) 474-0925 (518) 408-1745 (FAX)	Approved_____ Disapproved_____ Provider #_____ Date Notified_____ Renewal Date_____

Provider Determination and Agreement to Offer Infection Control Training

New Provider

Provider Information

Name of Facility or Individual:_____

Type of provider (check one if applicable)

☐ Hospital ☐ Long Term Care ☐ Home Care ☐ Independent CIC ☐ Other _____

Address:_____

City, State and Zip:_____

County:_____

Contact Person:_____Title:_____

Phone:_____ FAX:_____

E-mail:_____

Qualifications

For all Article 28 applicants and renewal applicants such as hospitals, long term care facilities and home care, the recommended qualifications for the course work instructors are (check those that apply):

- q Certification in infection control by the Certification Board of Infection Control and Epidemiology (CBIC), or,
- q Current experience in infection control.

For non-article 28 applicants and renewal applicants such as organizations and consultants, the required qualifications for the course work instructors are (check those that apply):

- q Current certification in infection control by CBIC, or,
- q Active in infection control practice within an institution for a minimum of 2 years, or,
- q Practicing infectious disease physician.

Target Audience: (Check all that apply)

- q Physicians
- q Registered Physician Assistants
- q Special Assistants
- q Podiatrists
- q Registered Nurses
- q Licensed Practical Nurses
- q Dentists
- q Dental Hygienist
- q Optometrists

Eligible Groups: (Check all that apply)

- q Employees
- q Credentialed/Affiliated Professionals
- q Community-based Providers

Instructor's Names: (Those who are actually responsible for teaching the course)

1) Name _____

Title _____

q RN q LPN q CIC q MPH q Other (describe)_____	q Ph.D q MD q BA q BS

Phone _____ FAX _____

E-Mail_____

2) Name _____

Title _____

q RN q LPN q CIC q MPH q Other (describe)_____	q Ph.D q MD q BA q BS

Phone _____ FAX _____

E-Mail_____

Terms of Agreement

- q Check Box The provider agrees that the course work or training will cover the core elements specified in the New York State Department of Health and New York State Education Department's Infection Control Training Syllabus (please call (518) 486-2938 to obtain a copy). The provider agrees that the course work will be tailored to meet the needs of the target audience and will be current, relevant and scientifically accurate.
- q Check Box The provider agrees that the instructional staff will possess the training, experience, or earned degrees necessary to insure that the educational goals of the program are met.
- q Check Box The provider agrees to issue a Certificate of Completion to training participants. The format must contain information set forth by the example included in each syllabus. The provider agrees to assume the cost of reproducing this or any other training related material. The provider further agrees to assume the cost of postage, handling, or any other cost associated with communicating with personnel of the Department of Health or complying with directives of this agency.
- q Check Box The provider agrees to maintain a record of course participants for not less than six (6) years from the date of the completion of the course. These records may be subject to the review of the Department of Health and the provider agrees to make these records available to the Department or its designee(s) during regular business hours. The provider also agrees to respond to inquiries from the Department regarding these documents.
- q Check Box The provider agrees that the Department of Health may review and evaluate the coursework or training offered and that termination of the provider's approved status may result if the Department determines that the course work is inadequate, incomplete, inaccurate or otherwise unsatisfactory.
- q Check Box The provider understands and agrees that failure to comply with this agreement may result in termination of the provider agreement by the New York State Department of Health.

Signature of Authorized Official

_____

(Print or Type Name)

_____

(Title)

_____

(Date)

_____